

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 14,457

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Appeal of)

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INTRODUCTION

The petitioner appeals a decision of the Department of Social Welfare denying coverage for an MRI based on a determination that it is not medically necessary.

FINDINGS OF FACT

1. The petitioner is a twenty-eight-year-old man who has been out of work since March of 1996 due to back pain which has been treated unsuccessfully for several years. He receives Medicaid as the incapacitated father of two children.
2. Since March of 1996, the petitioner has been treated by a physician who specializes in orthopaedics and rehabilitation of the spine. After assessing the petitioner he advised an MRI (magnetic resonance imaging) of the spine to rule out disc disease. A complete copy of his report is attached hereto as Exhibit No. One and is incorporated by reference herein.
3. In June of 1996, the petitioner requested Medicaid payment for an MRI of his thoracic spine as prescribed by his physician. The request was referred to "Healthpro", a private contractor who reviews Medicaid requests for the Department of Social Welfare. A physician employed by that contractor spoke via telephone on June 28, 1996, with the petitioner's physician who explained to him in detail why he was requesting the procedure.
4. On that same day the "Healthpro" physician made a determination not to recommend the request for the following reason:

I spoke to Dr. [name]. The doctor wants to rule out disc herniation as a cause for patient's back spasms and pain which radiate to anterior chest at times. A MRI of lumbar region was negative. Due to the fact that the patient's symptoms are not localized to one nerve root level it is highly unlikely to be secondary to a herniated disc, especially in light of the fact that the patient has similar complaints in the lumbar area and MRI of lumbar spine was negative. I do not recommend MRI of thoracic spine as medically

necessary.

5. Based on the above recommendation, the Department notified the petitioner and his physician on June 29, 1996, that the request for payment would be denied because it was deemed not medically necessary.

6. The petitioner's physician disagrees with the "Healthpro" assessment. Given the longevity of the petitioner's symptoms, he wanted to "reassure the patient that there was or was not a thoracic disc or other pathology that would be giving him his recurrent symptoms. For those reasons, I still recommend that the MRI be performed. If it is normal, so be it, but I think it is important to know." He advised the petitioner to appeal because it was still his professional recommendation that the MRI be performed.

7. There is no evidence which would contradict the petitioner's physician's assertion that an MRI would tell whether there was disc disease or not. Therefore, it is found that an MRI would advise the physician as to the existence of some disease of the thoracic disc. There is similarly no substantial evidence contradicting the physician's assessment that it is important to rule out this possible etiology of the petitioner's pain and it is therefore found to be medically necessary to do so.

ORDER

The decision of the Department is reversed.

REASONS

Under the Medicaid regulations, "diagnostic tests given to determine the nature and severity of an illness; e.g. X-rays" are covered when performed as an outpatient hospital service. M520. Regulation M730 also provides for general coverage of laboratory and radiology services including "diagnostic and therapeutic X-rays, including computerized axial tomography (CAT scans). The Department does not argue that MRI tests are not covered under the above regulations. Rather they argue that the petitioner's request for an MRI runs afoul of a general provision in M101 which states that the program covers only "medically necessary medical care and services".

The physician treating the petitioner in this case, who specializes in this field, has prescribed this test for the petitioner to ascertain whether he has disc disease and feels that it is important to establish that fact. There is no evidence which would indicate that the test is not designed to give that information to the physician or that ruling out such an etiology is not necessary in this case. The "Healthpro" physician's reason for denying authorization for the MRI is nothing more than an attempt to second-guess the treating physician as to the etiology of the problem based upon no personal knowledge of the patient and no demonstrated expertise in this area. In essence, the "Healthpro" physician is insinuating that the treating physician is on the wrong track here rather than assessing whether the procedure requested is likely to assist the physician in his own assessment and diagnosis of his patient. That surely is not the role of a reviewing physician under the Department's procedures for prior authorization.

The Department's regulations require as follows:

Routine payment will not be made for procedures falling into one or more of the following four categories. Written justification will have to be made by the physician and approved by the Medicaid Division before service is rendered.

1. New procedures of unproven value; or
2. Established procedures of questionable current usefulness; or
3. Procedures which tend to be redundant when performed in combination with other procedures; or
4. Diagnostic procedures which are unlikely to provide a physician with additional information when they are repeated.

Identification of such procedures is made through the Medical Necessity Program begun by Blue Shield with the assistance of the American College of Physician, American College of Radiology and American College of Surgeons. Also participating, is the American Academy of Family Practice, Council of Medical Specialties, American Hospital Association and American Association of Medical Colleges.

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The physician in this case has requested a fairly routine kind of diagnostic test. The Department has not shown that the test is new and of unproven value nor that it is an established procedure whose usefulness is currently under attack; nor has the Department shown that the MRI is redundant when performed with other procedures or that this is a repeat of a previously performed procedure. Given those facts, it is not even clear why this request for a diagnostic procedure was even subject to prior authorization review. As the Department's review and determination in this matter conflicts with its own regulations, the decision must be reversed and coverage should be authorized under either M520 or M730.

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